STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155546	A. BUILDING _____ B. WING _____	R-C 01/14/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHEL POINTE HEALTH AND REHAB	**3400 W COMMUNITY DR MUNCIE, IN 47304**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS This visit was for a Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 11/30/12. This visit included the PSR to the Investigation of Complaint IN00119089. Complaint # IN00119089 corrected Survey date: January 14, 2013 Facility number: 000565 Provider number: 155546 AIM number: 100267630 Survey team: Ginger McNamee, RN, TC Betty Retherford, RN Karen Lewis, RN Debora Barth, RN Census bed type: SNF: 16 SNF/NF: 68 Total: 84 Census payor type: Medicare: 18 Medicaid: 57 Other: 9 Total: 84 Bethel Pointe Health and Rehabilitation Center was found to be in compliance with 42 CFR part 483, subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and State Licensure Survey and the PSR to Complaint IN00119089.	{F 000}		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 Quality Review completed by Debora Barth, RN.	{F 000}		